PRINTED: 08/13/2014 FORM APPROVED OMB NO. 0938-0391

TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 000  INITIAL COMMENTS  The following citations represent the findings of complaint investigation #77943 and partial extended survey.  F 223  ABJUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by:  The facility had a census of 30 residents. The sample included 3 residents. Based on observation, interview, and record review the facility failed to provide 1 of 3 residents with a safe envrionment to be free from potential abuse		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	TIPLE CONSTI		COMI	E SURVEY PLETED
RAME OF PROVIDER OR SUPPLIER  GRISELL MEMORIAL HOSPITAL LTCU    SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   F 000      F 000   INITIAL COMMENTS   F 000   INITIAL COMMENTS   F 223   483.13(b), 483.13(c), 4			17E015	B. WING				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  The following citations represent the findings of complaint investigation #77943 and partial extended survey.  F 223 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARRY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by:  The facility had a census of 30 residents. The sample included 3 residents. Based on observation, interview, and record review the facility failed to provide 1 of 3 residents with a safe environment to be free from potential abuse			тси	1	330 S VE	RMONT PO BOX 268	, 55	
The following citations represent the findings of complaint investigation #77943 and partial extended survey.  F 223 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 3 residents. Based on observation, interview, and record review the facility failed to provide 1 of 3 residents with a safe envrionment to be free from potential abuse	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
complaint investigation #77943 and partial extended survey.  F 223 483.13(b), 483.13(c)(1)(i) FREE FROM F 223  ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 3 residents. Based on observation, interview, and record review the facility failed to provide 1 of 3 residents with a safe envrionment to be free from potential abuse	F 000	INITIAL COMMENTS	3	F	000			
by not immediately investagating Resident #1's accusation of abuse against a staff member, leaving the resident fearful.  Findings included:  Findings included:  - Resident #1's signed physician orders, dated 8/1/14, revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), worsening expressive aphasia (condition with		complaint investigation extended survey. 483.13(b), 483.13(c). ABUSE/INVOLUNTATATHE resident has the sexual, physical, and punishment, and involuntament, and involuntament, and involuntary seclusion.  The facility must not or physical abuse, continvoluntary seclusion.  This REQUIREMENT by: The facility had a cesample included 3 resobservation, interview facility failed to proving after environment to by not immediately in accusation of abuse leaving the resident for Findings included:  Findings included:  Resident #1's signer 8/1/14, revealed the dementia (progressive characterized by failing sincluded).	on #77943 and partial  (1)(i) FREE FROM  (RY SECLUSION  right to be free from verbal, I mental abuse, corporal coluntary seclusion.  use verbal, mental, sexual, corporal punishment, or  i.  T is not met as evidenced  msus of 30 residents. The esidents. Based on  w, and record review the de 1 of 3 residents with a be free from potential abuse envestagating Resident #1's against a staff member, rearful.  ed physician orders, dated following diagnoses: we mental disorder ng memory, confusion),	F	223			
disordered or absent language function), depression (abnormal emotional state	LADOR TOS	disordered or absent depression (abnorma	language function), al emotional state			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED
		17E015	B. WING		C 08/13/2014
	PROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572	1 00/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 223	characterized by exa sadness, worthlessnedegeneration (progre retina), and anxiety (characterized by appirrational fear).  The quarterly (MDS) assessment, dated 7 had intact cognition of for Mental Status scot behaviors exhibited, use of corrective lensindicated the resident his/her activities of dantianxiety, antidepremedication.  The 5/15/14 care pla with the resident durithe resident to find wassist the resident wineeded.  The 7/15/14 physicial the resident wanted was not capable to colonger.  The 8/3/14 at 5:00 President was visibly to which involved inappimember that had hap the note indicated the resident things would would be discussed supervisor on Mondal	ggerated feelings of ess and emptiness), macular essive deterioration of the mental or emotional reaction or ehension, uncertainty and  Minimum Data set 3.0  //29/14, indicated the resident with a (BIMS) Brief Interview or e of 13 without any and had impaired vision with ess. The MDS further it was independent with all of aily living and had received essant, and diuretic  In instructed the staff to visiting personal cares, to assist fords when needed, and to eith decision making as  In's progress note indicated to go home, but the resident are for him/herself any  M nurse's note revealed the upset regarding the incident propriate touching by a staff opened a few nights ago. He staff explained to the dipokay and the incident with the long term care	F 22	3	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	LE CONSTRUCTION  G	COMPLETED
		17E015	B. WING		C 08/13/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE  330 S VERMONT PO BOX 268  RANSOM, KS 67572	00/13/2014
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 223	shifts: - 7/30/14 6:00 PM to - 8/2/14 2:00 PM to - 8/3/14 6:00 PM to The 8/4/14 at 8:00 resident continued incident. The note in he/she did not slee note revealed the lonot available to discresident was concentim/her. At 6:30 PM resident had spoke supervisor, was enshandled, and the rease.  On 8/5/14 at 1:20 Fresident lying sidew an audio book. Conthe resident indeperconversation with the revealed the resident eyes bright red and discussed the incid touched by a staff resident nurse aide had	e C worked the following o 6:00 AM 10:00 PM	F 22		
	fondled the residen know you like it". The he/she yelled for the room.  On 8/6/14 at 2:11 Fresident independent with his/her walker.	t's chest, and stated "you ne resident continued to state e nurse's aide to leave his/her  M, observation revealed the ntly ambulated into the hallway Continued observation revesing the previous incident,			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		17E015	B. WING _			C 08/13/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572	<u> </u>	03.10.2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223	Continued From pag	e 3	F 2	23		
	the resident's eyes in flooded with tears. To concerned he/she w reporting the incident would be shot with a On 8/5/14 at 11:00 A stated he/she had be accused Nurse Aide him/her at 4:00 AM w passed. Administration after the resident has staff and the staff has administrative staff of Administrative Nurse F further veriff Sunday 8/3/14 the s reports and placed to of the quality improved Administrative Nurse was not aware of the improvement officer on Monday 8/5/14. A verified the only male the resident was Nurse and the worked a day shift.  On 8/5/14 at 1:35 PM Saturday 8/2/14, he/Nurse Aide B stated him/her, a few nights come into the resides slammed his/her ice	mmediately turned red and he resident became ould be in trouble for t and was frightful he/she gun by the accused staff.  MM, Administrative Nurse Feen notified the resident had C inappropriately touched when his/her water was we Nurse F further verified used to work the weekend d reported the incident to the d not notified the over the weekend.  F verified Nurse Aide C was ay 8/4/14, pending the stigation. Administrative sed on Saturday 8/2/14 and taff had filled out incident them in a locked box outside ement officer's office.  F further verified he/she incident until the quality notified him/her mid-morning administrative Nurse Fe aide who had worked with				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED
		17E015	B. WING		C 08/13/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE  330 S VERMONT PO BOX 268  RANSOM, KS 67572	1 33.15/2311
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)	D BE COMPLETION
F 223	on Saturday on 8/2/1 On 8/5/14 at 2:25 PN verified he/she review surveillance and reve the resident's room a deliver his/her water surveillance revealed resident's room for 1 On 8/5/14 at 2:40 PN resident notified him/ Sunday 8/3/14, and the incident to descri Nurse E verified the frightened the accus to work Sunday 8/3/1 he/she informed a M Nurse Aide C to work night, 8/3/14. On 8/5/14 at 3:35 PN he/she worked in the the residents on Saturation 8/3/14. On 8/5/14 a 4:16 PN resident had told him about the incident of him/her inappropriate he/she filled out an in 8/2/14 and Sunday 8/3/14, the accused staff (Nurse evening and had bro	d filled out an incident report 4.  //, Administrative Nurse F //wed the facility's video ealed Nurse Aide C was in at 4:12 AM on 7/31/14 to	F 22	3	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		17E015	B. WING			C 98/13/2014
	ROVIDER OR SUPPLIER	TCU		STREET ADDRESS, CITY, STATE, ZIP COD 330 S VERMONT PO BOX 268 RANSOM, KS 67572		0/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 223	Sunday 8/3/14, the rewhich was unusual dindependent with his/so the staff went to an Nurse Aide A reveale resident's room he/sh and requested help to he/she could reach it member (Nurse Aide since Nurse Aide C worder resident's in the had made the allegat inappropriately touch Staff G further verified his/her of the resident weekend and was not suspended pending the outcome. The facility's undated Exploitation policy incomposition family members and all alleged or suspect mistreatment, neglect immediately to the Accontinued to indicate abuse, neglect, or eximmediately suspend will leave the employed to the property until the and law enforcement is resolved.	I, Nurse Aide A stated on esident's call light went off, ue to the resident was ther activities of daily living, inswer the call light quickly. If a dupon entering the ne was found to be fearful to attach his/her call light so in case the accused staff (C) came in his/her room, was working that evening.  M, Administrative Staff G is had continued to work with the facility after the resident ions of him/her being ed for 2 days. Administrative in the staff had not notified it's accusations over the it made aware until Monday to Staff G verified Nurse Aide in until Monday 8/5/14, of the investigation.  Abuse, Neglect and dicated all facility employees, volunteers are educated that the dicated in the staff had not notified it is accusations.	F 23	23		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E015	B. WING		C 08/13/2014
	ROVIDER OR SUPPLIER	тси		STREET ADDRESS, CITY, STATE, ZIP CODE  330 S VERMONT PO BOX 268  RANSOM, KS 67572	1 00/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 223	Continued From page		F 22	3	
F 225 SS=J	environment free fron 483.13(c)(1)(ii)-(iii), (c INVESTIGATE/REPC ALLEGATIONS/INDIV	c)(2) - (4) PRT	F 22	5	
	been found guilty of a mistreating residents had a finding entered registry concerning al of residents or misap and report any knowle court of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would service as a nurse aide or ne State nurse aide registry s.			
	involving mistreatmer including injuries of u misappropriation of reimmediately to the ad to other officials in ac through established p State survey and cert	esident property are reported ministrator of the facility and cordance with State law procedures (including to the ification agency).  e evidence that all alleged whly investigated, and must tial abuse while the			
	The results of all inve to the administrator o representative and to with State law (includ certification agency) v incident, and if the all	stigations must be reported			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		17E015	B. WING		08/13/2014
	ROVIDER OR SUPPLIER	тси		STREET ADDRESS, CITY, STATE, ZIP CODE  330 S VERMONT PO BOX 268  RANSOM, KS 67572	1 00/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 225	Continued From pag	e 7	F 22	25	
	by: The facility had a ce sample included 3 re observation, interview facility failed to report administration, the aby Resident #1, and allegations of 1 of 3 rall residents in immediately and interview facility failed to report administration, the aby Resident #1, and allegations of 1 of 3 rall residents in immediately immediately failed and interview for Mental Status see the sample of corrective lens indicated the resident was accomplished.	w, and record review the t immediately to llegation of abuse reported effectively investigate residents. This failure placed diate jeopardy.  The deprice of a physician orders, dated following diagnoses: remental disorder remains and the following diagnoses: remental disorder remains and emptiness), macular resident resident remental or emotional reaction rehension, uncertainty and remains and following and had impaired vision with resident remains and the following and had received			

PRINTED: 08/13/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED	
		17E015	B. WING				C <b>13/2014</b>
	ROVIDER OR SUPPLIER MEMORIAL HOSPITAL L	тси		3	TREET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 RANSOM, KS 67572	1 00/	10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	with the resident during the resident to find wood assist the resident with needed.  The 7/15/14 physiciang the resident wanted to was not capable to callonger.  The 8/3/14 at 5:00 PM resident was visibly unwhich the resident allotouched by staff, had touched by staff, had the note indicated the resident things would would be discussed would be discussed would be discussed would would be discussed on the solution of th	in instructed the staff to visit and personal cares, to assist ords when needed, and to the decision making as  In sprogress note indicated to go home, but the resident are for him/herself any  If nurse's note revealed the pset regarding the incident, and the egated being inappropriately happened a few nights ago. The staff explained to the be okay and the incident with the long term care by.  If gust 2014 nursing schedule C worked the following  If nurse's note indicated the be upset regarding the licated the resident stated at all the night before. The g term care supervisor was ses the incident and the ed no one would believe	F	225			
	him/her. At 6:30 PM, resident had spoke w supervisor, was ensu						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E015	B. WING		C 08/13/2014
	ROVIDER OR SUPPLIER MEMORIAL HOSPITAL I	тси	3	STREET ADDRESS, CITY, STATE, ZIP CODE 130 S VERMONT PO BOX 268 RANSOM, KS 67572	1 00/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 225	ease.  On 8/5/14 at 1:20 PN resident lying sidewa an audio book. Contithe resident independent independent in the revealed the resident eyes bright red and for discussed the incident touched by a staff male nurse aide had 4:00 AM, sat down hondled the resident's know you like it". The	ident felt a little more at  A, observation revealed the eys on his/her bed listening to nued observation revealed dently sat up and engaged in a surveyor. Observation to became tearful, with his/her illed with tears when he/she ent of being inappropriately ember. The resident stated a come into his/her room at is/her water pitchure and had so chest, and stated "you e resident continued to state nurse's aide to leave his/her	F 225		
	resident independent with his/her walker. Or revealed when discust the resident's eyes in flooded with tears. The concerned he/she were porting the incident would be shot with a On 8/5/14 at 11:00 A stated he/she had be accused Nurse Aide him/her at 4:00 AM we passed. Administrative Nurse Aide C continuafter the resident had staff and the staff had administrative staff or	ould be in trouble for and was frightful he/she gun by the accused staff.  M, Administrative Nurse For notified the resident had C inappropriately touched when his/her water was we Nurse F further verified and to work the weekend direported the incident to the direct notified the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		17E015	B. WING		C 08/13/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 225	suspended on Mondo outcome of the invest Nurse F further veriff Sunday 8/3/14 the sreports and placed the of the quality improvement officer on Monday 8/5/14. A verified the only make the resident was Nurse mployed male aide the resident and the worked a day shift.  On 8/5/14 at 1:35 PN Saturday 8/2/14, he/Nurse Aide B stated him/her, a few nights come into the resides slammed his/her ice table, and had fonded be verified he/she had on Saturday on 8/2/10.  On 8/5/14 at 2:25 PN verified he/she revies surveillance and reviet the resident's room and deliver his/her water surveillance revealed resident notified him Sunday 8/3/14, and the incident to describe the surveillance to describe the incident	lay 8/4/14, pending the stigation. Administrative ied on Saturday 8/2/14 and taff had filled out incident hem in a locked box outside ement officer's office.  The Further verified he/she incident until the quality notified him/her mid-morning administrative Nurse Fee aide who had worked with rese Aide C, the other in the facility, is a friend of male agency aide had  M. Nurse Aide B stated on she visited with the resident. The resident had revealed to sprior, a staff member had nt's room around 4:00 AM, water down on the bedside ed his/her chest. Nurse Aide d filled out an incident report 14.  M. Administrative Nurse Fewed the facility's video ealed Nurse Aide C was in at 4:12 AM on 7/31/14 to	F 22	5	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	, ,	E SURVEY MPLETED
		17E015	B. WING _			C 8/13/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572		0/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	Continued From pag	e 11	F 2	25		
	frightened the accus to work Sunday 8/3/he/she informed a M Nurse Aide C to work night 8/3/14.  On 8/5/14 at 3:35 PM he/she worked in the the residents on Sate 8/3/14.  On 8/5/14 a 4:16 PM resident had told him	ed staff member was going 14, night. Nurse E stated edication Aide not to allow k with the resident on Sunday  M, Nurse Aide C verified e facility and provided care to urday 8/2/14 and Sunday  I, Nurse Aide D verified the h/her on Saturday 8/2/14, a staff member touching				
	him/her inappropriate he/she filled out an in 8/2/14 and Sunday 8 on Sunday 8/3/14, th accused staff (Nurse evening and had bro	ely. Nurse Aide D verified incident report on Saturday 6/3/14. Nurse Aide D stated ite resident told him/her the e Aide C) would work that ke down in tears and had d the call light close and did				
	Sunday 8/3/14, the r which was unusual of independent with his so the staff went to a Nurse Aide A reveale resident's room he/s and requested help the/she could reach in member (Nurse Aide County) On 8/6/14 at 12:15 Fiverified Nurse Aide County	M, Nurse Aide A stated on esident's call light went off, lue to the resident was /her activities of daily living, answer the call light quickly. Ed upon entering the he was found to be fearful to attach his/her call light so it in case the accused staff of C) came in his/her room, was working that evening.  PM, Administrative Staff G chad continued to work with the facility after the resident tions of him/her being				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E015	B. WING _			C 08/13/2014	
NAME OF PR	ROVIDER OR SUPPLIER	2010	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		18/13/2014	
			330 S VERMONT PO BOX 268				
GRISELLI	MEMORIAL HOSPITAL L	ICU		RANSOM, KS 67572			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 225	Continued From page	e 12	F 2	225			
	Staff G further verified his/her of the resident weekend and was not 8/5/14. Administrative C was not suspended pending the outcome  The facility's undated Exploitation policy indifamily members and all alleged or suspect mistreatment, neglect immediately to the Adcontinued to indicate abuse, neglect, or expimmediately suspendivill leave the employr to the property until the	Abuse, Neglect and licated all facility employees, volunteers are educated that ed violations involving or abuse are reported ministrator. The policy any alleged perpetrator of					
F 250	residents during the in placed all residents in The immediate jeopar when the facility compoursing staff on how to notify administrative sabuse and residents finvestigation has been the deficient practice severity of an F.	ons of abuse, and protect all nvestigation. This failure immediate jeopardy.  Independent of the state of the	F2	250			
1 200	700. 10(g)(1) FROVIS	NON OF WILDIOALLY	12				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DPLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		17E015	B. WING		C 08/13/2014	
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE  330 S VERMONT PO BOX 268  RANSOM, KS 67572	, 03.10.20	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 250 SS=D	services to attain or	SERVICE  vide medically-related social maintain the highest mental, and psychosocial	F 25	0		
	by: The facility had a ce sample included 3 re observation, intervie facility failed to prov Resident #1 after all	T is not met as evidenced ensus of 30 residents. The esidents. Based on ew, and record review the ide pychosocial services to egations of abuse were sident remained tearful and				
	8/1/14, revealed the dementia (progressi characterized by fail worsening expressive disordered or absendepression (abnorm characterized by exadness, worthless degeneration (progretina), and anxiety	ing memory, confusion), re aphasia (condition with t language function),				
	assessment, dated	) Minimum Data set 3.0 7/29/14, indicated the resident with a (BIMS) Brief Interview				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E015	B. WING		C 08/13/2014	
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE  330 S VERMONT PO BOX 268  RANSOM, KS 67572	, 33.16.2511	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 250	behaviors exhibited, use of corrective len indicated the residen his/her activities of cantianxiety, antideprimedications.  The 5/15/14 care plawith the resident to find vassist the resident with the resident was not capable to colonger.  The 8/3/14 at 5:00 Fresident was visibly which the resident hinappropriately touch happened a few night the staff explained to okay and the incident the long term care services.	ore of 13 without any and had impaired vision with ses. The MDS further at was independent with all of laily living and had received	F 25	<u> </u>		
	shifts: - 7/30/14 6:00 PM to - 8/2/14 2:00 PM to - 8/3/14 6:00 PM to The 8/4/14 at 8:00 A resident continued to incident. The note in	6:00 AM 10:00 PM				

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		17E015	B. WING		C 08/13/2014
NAME OF PROVIDER OR SUPPLIER  GRISELL MEMORIAL HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE  330 S VERMONT PO BOX 268  RANSOM, KS 67572	1 00/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 250	Continued From page		F 25	0	
	not available to discuresident was concern him/her. At 6:30 PM, resident had spoke was upervisor, was ensure handled, and the residenters.  Review of the medical documentation the fathe psychosocial need.  On 8/5/14 at 1:20 PM resident lying sidewa an audio book. Continuther resident independenters on the resident eyes bright red and findiscussed the incidenter touched by a staff memale nurse aide had 4:00 AM, sat down his fondled the resident's know you like it". The he/she yelled for the room.  On 8/6/14 at 2:11 PM resident independent with his/her walker. Crevealed when discussed was entered to the revealed when discussed the independent with his/her walker. Crevealed when discussed the resident independent with his/her walker. Crevealed when discussed the resident independent with his/her walker. Crevealed when discussed the resident independent with his/her walker. Crevealed when discussed the resident independent with his/her walker. Crevealed when discussed the resident independent with his/her walker. Crevealed when discussed the resident independent with his/her walker. Crevealed when discussed the resident independent with his/her walker. Crevealed when discussed the resident independent with his/her walker. Crevealed when discussed the resident independent with his/her walker.	I, observation revealed the ys on his/her bed listening to nued observation revealed dently sat up and engaged in surveyor. Observation became tearful, with his/her lled with tears when he/she at of being inappropriately ember. The resident stated a come into his/her room at s/her water pitchure and had a chest, and stated "you resident continued to state nurse's aide to leave his/her			
		and was frightful he/she gun by the accused staff.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BOILD	_		(	С
		17E015	B. WING			08/	13/2014
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL	LTCU		3	STREET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 250	stated he/she had be accused Nurse Aide him/her at 4:00 AM passed. Administrative Nurse Aide C continuafter the resident has staff and the staff has administrative Staff Administrative Nurse Suspended on Moncoutcome of the invenues of the invenues F further verification of the quality improving Administrative Nurse was not aware of the improvement officer on Monday 8/5/14. Verified the only mathe resident was Nuemployed male aided the resident and the worked a day shift.  On 8/5/14 at 1:35 P Saturday 8/2/14, he Nurse Aide B stated him/her, a few night come into the resides slammed his/her ice table, and had fond B verified he/she has on Saturday on 8/2/On 8/5/14 at 2:25 P	AM, Administrative Nurse F ween notified the resident had be C inappropriately touched when his/her water was tive Nurse F further verified hued to work the weekend and reported the incident to the land not notified the lover the weekend. It is a resident in the resident. If the resident in the resident. If the resident in the resid	F	250			
		vealed Nurse Aide C was in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 250	deliver his/her water surveillance revealed	at 4:12 AM on 7/31/14 to	F 2	250			
	resident notified him Sunday 8/3/14, and the incident to descr Nurse E verified the frightened the accus to work Sunday 8/3/ he/she informed a M Nurse Aide C to work night, 8/3/14. On 8/5/14 at 3:35 PM he/she worked in the	M, Nurse E stated the /her of the incident on the resident had reenacted ibe what had happened. resident was tearful and ed staff member was going 14, night. Nurse E stated ledication Aide not to allow k with the resident on Sunday  M, Nurse Aide C verified e facility and provided care to urday 8/2/14 and Sunday					
	resident had told him about the incident of him/her inappropriate he/she filled out an it 8/2/14 and Sunday 8 on Sunday 8/3/14, th accused staff (Nurse evening and had brostated he/she wante not feel safe.  On 8/5/14 at 4:41 PN Sunday 8/3/14, the rewhich was unusual coindependent with his	M, Nurse Aide D verified the h/her on Saturday 8/2/14, if a staff member touching ely. Nurse Aide D verified incident report on Saturday 8/3/14. Nurse Aide D stated he resident told him/her the exaide C) would work that exist down in tears and had did the call light close and did with the call light close and did with the exist of the resident was solved a state of the resident was solved and the call light went off, the call light quickly.					

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F 250	and requested help to he/she could reach it member (Nurse Aide C vorse	ne was found to be fearful to attach his/her call light so attach his/her call light so at in case the accused staff C) came in his/her room, was working that evening.  M. Administrative Staff G C had continued to work with the facility after the resident attions of him/her being attended to the staff had not notified attended to the staff had not notified attended aware until Monday to estaff G verified Nurse Aide duntil Monday 8/5/14, at of the investigation.  M. Administrative Nurse F social service designee was anly psychosocial care the mentile his/her child, visiting with a divisiting with Admibistrative ive Nurse F verified the early upset and fearful and	F 250			